

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10380 CERTIFICATE OF DEATH

10370

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 SHOFFERS NURSING HOME</u>				d. STREET ADDRESS <u>ROGERS AVE RT 3</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRIS WOODWARD BEDISH</u>				4. DATE OF DEATH Month Day Year <u>OCT. 12, 1956</u> 19			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 26, 1901</u> 35 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		9. AGE (In years last birthday) <u>55</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>LODGE, KENTUCKY</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>JOHN F WOODWARD</u>				14. MOTHER'S MAIDEN NAME <u>MATTIE LOVELACE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT Address <u>MRS. OTTO COTT, BETHESDA, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-11</u> , 19 <u>56</u> , to <u>10-12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-12-56</u> , 19 <u>56</u> , and that death occurred at <u>4:45</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Peter V Thorpe</u> M.D. <u>COLUMBIA RD</u>				PHYSICIAN'S NAME (Type) <u>PETER V THORPE, MD ELLICOTT CITY, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>FCHIGLIN BATHOM, ELLICOTT CITY, Md.</u>				24a. REC'D BY REGISTRAR <u>OCT 16 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>	

BUREAU V. S.

OCT 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10381

CERTIFICATE OF DEATH

Reg. Dist. No.

10371491

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Annapolis Road				d. STREET ADDRESS Old Annapolis Road			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First HARRY Middle THOMAS Last GERWIG				4. DATE OF DEATH Month October Day 12 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-15-1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Gerwig				14. MOTHER'S MAIDEN NAME Ardella Grimes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Daisy Gerwig, Ellicott City, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary atherosclerosis DUE TO (c) Cerebral thrombosis & left hemiparesis (11 mo.)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 8 , 1955, to Oct. 11 , 1956, that I last saw the deceased alive on Sept. 12 , 1956, and that death occurred at 10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Ellicott City, Md. DATE SIGNED Oct. 12, 1956							
ACTUAL SIGNATURE Donald E. Fisher M.D.							
PHYSICIAN'S NAME (Type) Donald E. Fisher M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR 016161956		24b. REGISTRAR'S SIGNATURE J. E. Loughran	

CERTIFICATE OF DEATH

10523

1. NAME OF DECEASED HARRIS, JAMES		2. SEX Male		3. AGE 65	
4. DATE OF BIRTH 1890		5. PLACE OF BIRTH Maryland		6. OCCUPATION Farmer	
7. DATE OF DEATH October 12, 1956		8. PLACE OF DEATH Home		9. CAUSE OF DEATH Heart Disease	
10. MEDICAL HISTORY Hypertension, Atherosclerosis		11. PRESENT ILLNESS Chest pain, shortness of breath		12. DATE OF ONSET October 10, 1956	
13. PHYSICIAN'S NAME Dr. J. H. Smith		14. HOSPITAL NAME St. Joseph's Hospital		15. DATE OF ADMISSION October 11, 1956	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF REGISTRAR J. H. Smith		18. SIGNATURE OF DECEASED James Harris	
19. SIGNATURE OF NEXT OF KIN Mrs. J. H. Harris		20. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith		21. SIGNATURE OF DECEASED James Harris	
22. SIGNATURE OF DECEASED James Harris		23. SIGNATURE OF DECEASED James Harris		24. SIGNATURE OF DECEASED James Harris	
25. SIGNATURE OF DECEASED James Harris		26. SIGNATURE OF DECEASED James Harris		27. SIGNATURE OF DECEASED James Harris	
28. SIGNATURE OF DECEASED James Harris		29. SIGNATURE OF DECEASED James Harris		30. SIGNATURE OF DECEASED James Harris	
31. SIGNATURE OF DECEASED James Harris		32. SIGNATURE OF DECEASED James Harris		33. SIGNATURE OF DECEASED James Harris	
34. SIGNATURE OF DECEASED James Harris		35. SIGNATURE OF DECEASED James Harris		36. SIGNATURE OF DECEASED James Harris	
37. SIGNATURE OF DECEASED James Harris		38. SIGNATURE OF DECEASED James Harris		39. SIGNATURE OF DECEASED James Harris	
40. SIGNATURE OF DECEASED James Harris		41. SIGNATURE OF DECEASED James Harris		42. SIGNATURE OF DECEASED James Harris	
43. SIGNATURE OF DECEASED James Harris		44. SIGNATURE OF DECEASED James Harris		45. SIGNATURE OF DECEASED James Harris	
46. SIGNATURE OF DECEASED James Harris		47. SIGNATURE OF DECEASED James Harris		48. SIGNATURE OF DECEASED James Harris	
49. SIGNATURE OF DECEASED James Harris		50. SIGNATURE OF DECEASED James Harris		51. SIGNATURE OF DECEASED James Harris	
52. SIGNATURE OF DECEASED James Harris		53. SIGNATURE OF DECEASED James Harris		54. SIGNATURE OF DECEASED James Harris	
55. SIGNATURE OF DECEASED James Harris		56. SIGNATURE OF DECEASED James Harris		57. SIGNATURE OF DECEASED James Harris	
58. SIGNATURE OF DECEASED James Harris		59. SIGNATURE OF DECEASED James Harris		60. SIGNATURE OF DECEASED James Harris	
61. SIGNATURE OF DECEASED James Harris		62. SIGNATURE OF DECEASED James Harris		63. SIGNATURE OF DECEASED James Harris	
64. SIGNATURE OF DECEASED James Harris		65. SIGNATURE OF DECEASED James Harris		66. SIGNATURE OF DECEASED James Harris	
67. SIGNATURE OF DECEASED James Harris		68. SIGNATURE OF DECEASED James Harris		69. SIGNATURE OF DECEASED James Harris	
70. SIGNATURE OF DECEASED James Harris		71. SIGNATURE OF DECEASED James Harris		72. SIGNATURE OF DECEASED James Harris	
73. SIGNATURE OF DECEASED James Harris		74. SIGNATURE OF DECEASED James Harris		75. SIGNATURE OF DECEASED James Harris	
76. SIGNATURE OF DECEASED James Harris		77. SIGNATURE OF DECEASED James Harris		78. SIGNATURE OF DECEASED James Harris	
79. SIGNATURE OF DECEASED James Harris		80. SIGNATURE OF DECEASED James Harris		81. SIGNATURE OF DECEASED James Harris	
82. SIGNATURE OF DECEASED James Harris		83. SIGNATURE OF DECEASED James Harris		84. SIGNATURE OF DECEASED James Harris	
85. SIGNATURE OF DECEASED James Harris		86. SIGNATURE OF DECEASED James Harris		87. SIGNATURE OF DECEASED James Harris	
88. SIGNATURE OF DECEASED James Harris		89. SIGNATURE OF DECEASED James Harris		90. SIGNATURE OF DECEASED James Harris	
91. SIGNATURE OF DECEASED James Harris		92. SIGNATURE OF DECEASED James Harris		93. SIGNATURE OF DECEASED James Harris	
94. SIGNATURE OF DECEASED James Harris		95. SIGNATURE OF DECEASED James Harris		96. SIGNATURE OF DECEASED James Harris	
97. SIGNATURE OF DECEASED James Harris		98. SIGNATURE OF DECEASED James Harris		99. SIGNATURE OF DECEASED James Harris	
100. SIGNATURE OF DECEASED James Harris		101. SIGNATURE OF DECEASED James Harris		102. SIGNATURE OF DECEASED James Harris	

BUREAU V. S.

OCT 16 1956

RECEIVED

CERTIFICATE OF DEATH

10372

Reg. Dist. No.

191

1. PLACE OF DEATH o. COUNTY <u>HOWARD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELLICOTT CITY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HIGHLAND MANOR CONVS. HOME</u>				d. STREET ADDRESS <u>413 N. ROSE ST.</u>			
3. NAME OF DECEASED (Type or print) <u>CHRISTIAN</u> First <u>J.</u> Middle <u>HEROLD</u> Last				4. DATE OF DEATH <u>OCT.</u> Month <u>23</u> Day <u>1956</u> Year			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 3, 1867</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TYPESETTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>ANTHONY</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>		17. INFORMANT <u>MARIE SCHAFER</u> Address <u>413 N. ROSE ST.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>10/4</u> , 19 <u>56</u> , to <u>10/22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/10</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Max J Miller</u>				ADDRESS (Street, city or town, state) <u>5226 BACT. NAT. PIKE</u>			
DATE SIGNED _____							
PHYSICIAN'S NAME (Type) <u>MAX J MILLER MD</u>							
22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HOLY RED EMBER CEM.</u>		22d. LOCATION (City, town, or county) <u>BALTIMORE</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BDABROWSKI 2818 E. BALTIMORE ST.</u>				24a. REC'D BY REGISTRAR <u>25 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Dougherty</u>	

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CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		RELIGION [Faint text]	
MARITAL STATUS [Faint text]		PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JURY [Faint text]		SIGNATURE OF JUDGE [Faint text]	
SIGNATURE OF CLERK [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF CHIEF CLERK [Faint text]	

BUREAU V. 5

11 25 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10373

10383

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Orange	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 14 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaeffers Conv. Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Walden d. STREET ADDRESS 18 Riverview st.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First AGNES Middle RUSSELL Last JOCELYN		4. DATE OF DEATH Month October Day 24 Year 19 56	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1875	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret)		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ? Abracombrie		14. MOTHER'S MAIDEN NAME (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Alden Jocelyn		203 Hammonds Ferry Rd Linthicum Heights, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) not known		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-22 , 19 56 , to 10-24 , 19 56 , that I last saw the deceased alive on 10-22 , 19 56 , and that death occurred at 3:20 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) COLUMBIA RD DATE SIGNED ACTUAL SIGNATURE Peter V Thorpe M.D. PETER V THORPE, M.D. ELlicott City Md PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 29/56	
22c. NAME OF CEMETERY OR CREMATORY Cypress Hills Cem.		22d. LOCATION (City, town, or county) (State) Brooklyn, New York	
23. FUNERAL DIRECTOR'S SIGNATURE Richard J. Singleton		24a. REC'D BY REGISTRAR John B. Bunn, Md	
24b. REGISTRAR'S SIGNATURE J. B. Bunn		DATE OCT 29 1956	

CERTIFICATE OF DEATH

NAME

NEW YORK

RESIDENCE

NEW YORK

DATE OF BIRTH

1901

1901

SEX

MALE

MALE

EDUCATION

EDUCATION

EDUCATION

DATE OF DEATH

1901

1901

PLACE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

DATE OF BURIAL

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BUREAU V. S.

OCT 29 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 190...

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>St Marys</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN	
X TOWN <u>Elkridge (Howard)</u>	<u>1 mo</u>	<u>Hollywood</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>7220 Elm Ave</u>		<u>Elkridge 27 md</u>	<u>18X-2</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>Annie's Mariech Joy</u>		<u>Oct 16 1936</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>white</u>	<u>Widowed</u>	<u>Apr 5 - 1876</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>80</u> yrs.		Months	Days
		Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>housewife</u>		<u>Housewife</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>St Marys Md</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>William Henry Dean</u>		<u>Dean</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>		<u>none</u>	
17. INFORMANT & ADDRESS:			
<u>Sherman Joy, Hollywood Md</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>apoplexy</u>			<u>6 days</u>
ANTECEDENT CAUSE (S): DUE TO (B) <u>arterial hypertension</u>			<u>54 yrs</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chr Myocarditis</u>			<u>1 yr</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Sclerosis</u>			<u>1 yr</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 15 1936</u> to <u>Oct 16 1936</u> that I last saw the deceased alive on <u>Oct 16, 1936</u> , and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. B. Brumbaugh</u>		DATE SIGNED <u>9/16/36</u>	
M. D. <u>3605 1/2 St. 27 md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>10/19/36</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Wagoner</u>		<u>Hollywood Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Oct 16, 1936</u>		<u>L. D. Miller</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>W. Blake Mattingly</u>		<u>Leonardtown</u>	

RECEIVED
OCT 18 1956
BUREAU V. S.

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "copy" and "letter" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10375

10385

CERTIFICATE OF DEATH

Reg. Dist. No.....

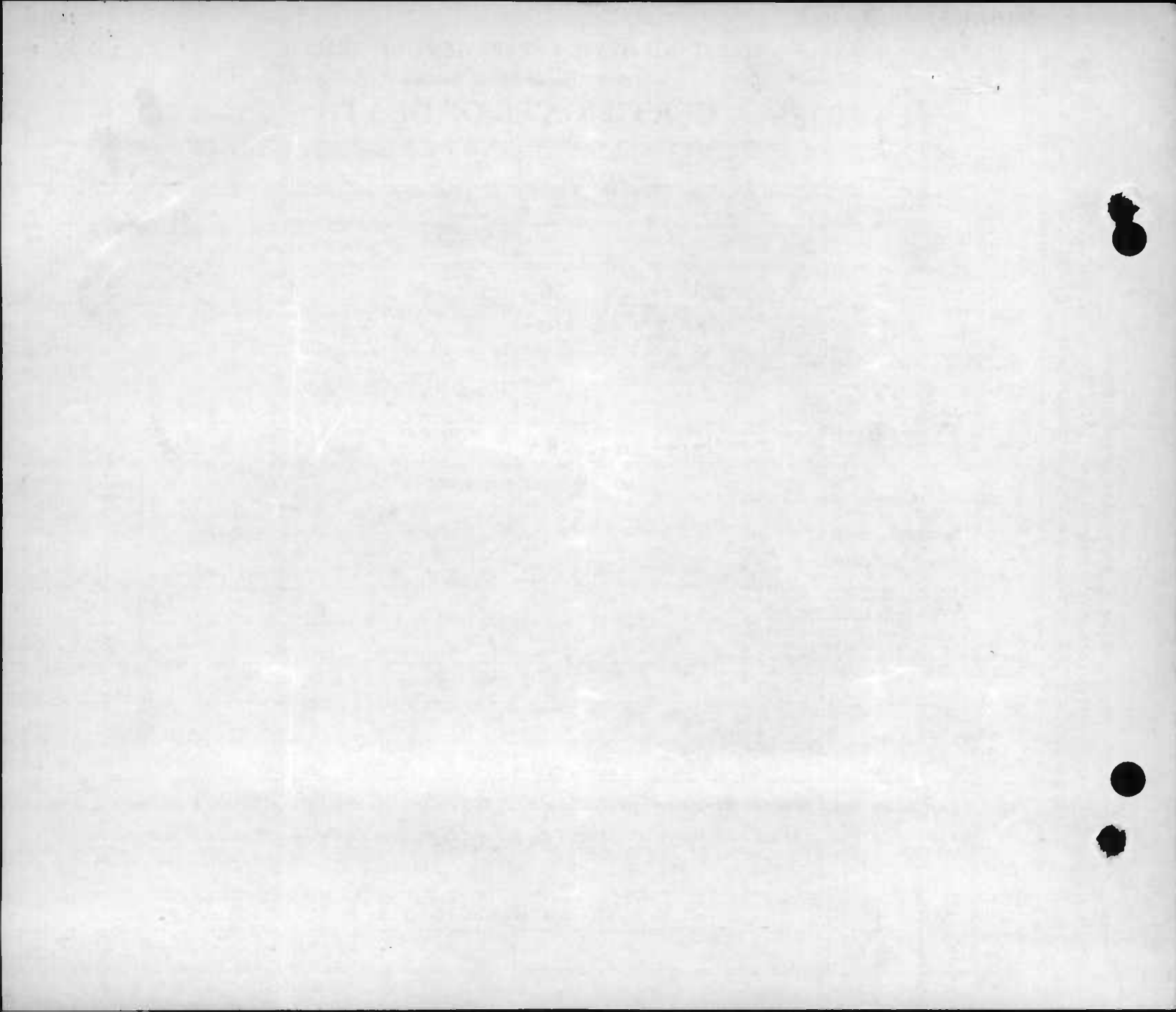
1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Elkridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>5518 Main St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>FRANK</u> (Middle) <u>JOSEPH</u> (Last) <u>PETRLIK</u>		4. DATE OF DEATH (Month) <u>Oct.</u> (Day) <u>4th</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>June 15, 84</u>
9. AGE last birthday <u>72</u> yrs.		If under 1 year: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Showerman</u>	
11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Petrlik</u>		14. MOTHER'S MAIDEN NAME <u>Kattun</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>213-20-0685</u>	
17. INFORMANT AND ADDRESS <u>Ann M. Petrlik, Elkridge, Md</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
177x Immediate cause (a) <u>Prostatitis to liver</u>		<u>3-4 months</u>	
Antecedent cause(s) (b) <u>Carcinoma of prostate</u>		<u>3 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic heart disease & cerebral</u>		<u>18 months</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerotic heart disease & cerebral</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u> </u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u> </u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u>	INJURY OCCURRED While at <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u> </u>	
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>45</u> , to <u>Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 3</u> , 19 <u>56</u> , and that death occurred at <u>11:20 A.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Guinn P. Gumbly M.D.</u>		ADDRESS <u>Relay 27, Md</u> DATE SIGNED <u>Oct 4th 56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>10-10-56</u>	NAME OF CEMETERY OR CREMATORY <u>St Augustines</u>	LOCATION (City, town, or county) (State) <u>Howard Co. Md.</u>
DATE REC'D BY LOCAL REG. <u> </u>	REGISTRAR'S SIGNATURE <u> </u>	24. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Rd</u> ADDRESS <u> </u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.



10386

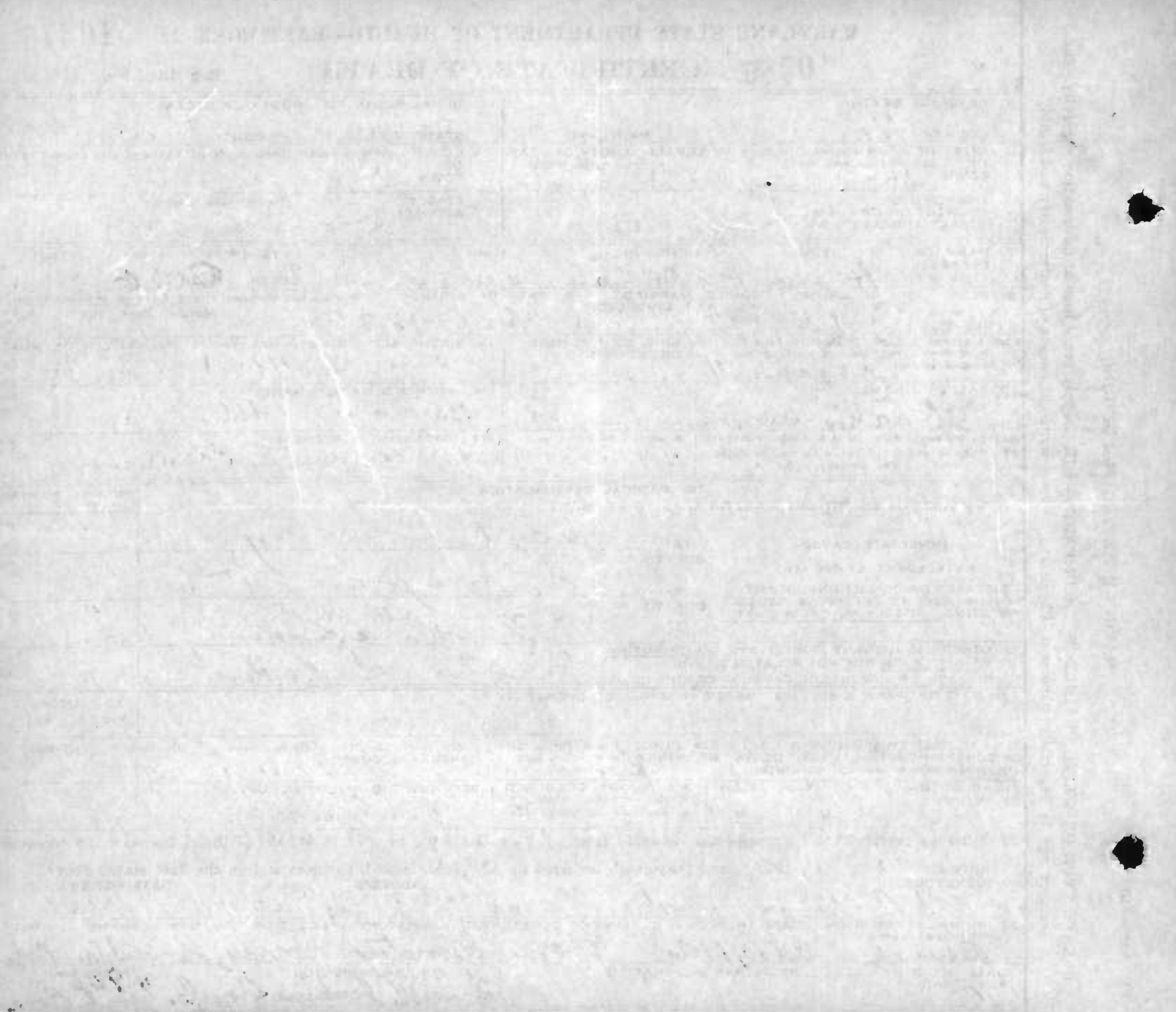
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X Dorsey</u>		LENGTH OF STAY (in this place) <u>6 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dorsey</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100 Dorsey Rd</u>				STREET ADDRESS (If rural give location) <u>Dorsey Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Henry Napoleon Riemensnyder</u>				<u>Oct 6 1956</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>apr 13-1977 79</u>	
9. AGE last birthday: <u>78 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>blacksmith B & C RR</u>		11. BIRTHPLACE (State or foreign country): <u>aa-co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>usa</u>	
13. FATHER'S NAME: <u>Charles Riemensnyder</u>				14. MOTHER'S MAIDEN NAME: <u>Barbara Miller</u>			
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-03-0079</u>		17. INFORMANT & ADDRESS: <u>Mrs Anna L. Riemensnyder</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>430.1 acute coronary occlusion</u>							<u>2 da.</u>
ANTECEDENT CAUSE (B) <u>due to</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>due to</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>903.0 general arteriosclerosis stroke atherosclerosis</u>							<u>14 yrs</u>
19A. DATE OF OPERATION:							20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19B. MAJOR FINDINGS OF OPERATION							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>home</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>Dorsey, Howard Md</u>		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>8 P. M.</u>			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell walking in yard</u>		
22. I hereby certify that I attended the deceased from <u>Jan 2, 1976</u> to <u>Oct 6, 1956</u> , that I last saw the deceased alive on <u>Oct 6, 1976</u> , and that death occurred at <u>10:02</u> M, from the causes and on the date stated above.							
SIGNATURE <u>A. B. Brumbaugh</u>				ADDRESS <u>1609 Main St</u>		DATE SIGNED <u>10/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct 10, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Gion Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dorsey, Howard Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 8, 1956</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Henry W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10377

10387

CERTIFICATE OF DEATH

Reg. Dist. No.

191

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shaffer Convalescent Home</u>			d. STREET ADDRESS <u>526 N. Loudon Ave.</u>		
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>H.</u> Last <u>Sewell</u>			4. DATE OF DEATH Month <u>October</u> Day <u>2</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 26, 1888</u>		9. AGE (In years lost birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>		11. BIRTHPLACE (State or foreign country) <u>Richmond, Virginia</u>	
13. FATHER'S NAME <u>Sidney Herndon</u>			14. MOTHER'S MAIDEN NAME <u>Frances Rives</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT <u>M. Edward Sewell-1764 Stanley Blvd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Several vascular accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive CV disease</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1</u> , 19 <u>56</u> , to <u>Oct. 2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 1</u> , 19 <u>56</u> , and that death occurred at <u>5 P</u> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Dr. A. Kochman</u>		ADDRESS (Street, city or town, state) <u>1037 N. Calvert St. Baltimore Md</u>			
PHYSICIAN'S NAME (Type) <u>Dr. A. Kochman</u>		DATE SIGNED <u>10/2/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/5/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	
				22d. LOCATION (City, town, or county) (State) <u>Richmond, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>			ADDRESS <u>4600 Liberty Hghts. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>1956</u>
					24b. REGISTRAR'S SIGNATURE <u>J. B. Longbrun</u>

CERTIFICATE OF DEATH

10378

Reg. Dist. No.

10388

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>SAME</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL RURAL</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARDING RD</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>AMOS</u> Middle <u>ELLSWORTH</u> Last <u>SOUDER</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11, 1890</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE T SOUDER</u>		14. MOTHER'S MAIDEN NAME <u>MARY FRANCES MURPHY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-05-8844</u>	
17. INFORMANT <u>LOIS SOUDER - WIFE - SAME ADDRESS.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 MYOCARDIAL INFARCTION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/12</u> , 19 <u>56</u> , to <u>10/13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/13</u> , 19 <u>56</u> , and that death occurred at <u>2:05</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John R. Buell</u>		ADDRESS (Street, city or town, state) <u>402 Main St. Laurel Md.</u>	
PHYSICIAN'S NAME (Type) <u>John R. BUELL</u>		DATE SIGNED <u>10/13/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/16/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Scaggsville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>De W. Sullivan, Laurel Md</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>D. H. Hedrick</u>	
DATE <u>19 1956</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 19 1956

RECEIVED

10389

CERTIFICATE OF DEATH

Reg. Dist. No.

197

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodstock</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLARA BELLE STANSFIELD</u>				4. DATE OF DEATH Month Day Year <u>October 29 1956</u>			
5. SEX <u>St.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 25, 1884</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilford D. Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Frances Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Oscar Stansfield - Woodstock, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Coronary Heart Disease,</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anemia, pylorogastitis, Cystitis</u> DUE TO (c) <u>Aspirin</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19____, to <u>Oct 29, 1956</u> , that I last saw the deceased alive on <u>29 Oct 1956</u> , and that death occurred at <u>2:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sykesville, MD 29 Oct 56</u>			
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				<u>SYKESVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Vernon</u>		22d. LOCATION (City, town, or county) (State) <u>Howard, Co., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur N. Haight - Sykesville, MD</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 7 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Alice Kelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. RACE <i>White</i>		5. BIRTH DATE <i>1911</i>		6. BIRTH PLACE <i>MD</i>	
7. DECEASED AT <i>Home</i>		8. PLACE OF DEATH <i>Home</i>		9. DATE OF DEATH <i>Nov 2 1956</i>	
10. TIME OF DEATH <i>10:00 AM</i>		11. CAUSE OF DEATH <i>Heart Disease</i>		12. MANNER OF DEATH <i>Natural</i>	
13. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		14. SIGNATURE OF REGISTRAR <i>John Doe</i>		15. SIGNATURE OF WITNESS <i>John Doe</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		18. SIGNATURE OF CLERK <i>John Doe</i>	
19. SIGNATURE OF CHURCH CLERK <i>John Doe</i>		20. SIGNATURE OF BURIAL CLERK <i>John Doe</i>		21. SIGNATURE OF CREMATION CLERK <i>John Doe</i>	
22. SIGNATURE OF INTERMENT CLERK <i>John Doe</i>		23. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		24. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
25. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		26. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		27. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
28. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		29. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		30. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
31. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		32. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		33. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
34. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		35. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		36. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
37. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		38. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		39. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
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43. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		44. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		45. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
46. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		47. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		48. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
49. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		50. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		51. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
52. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		53. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		54. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
55. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		56. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		57. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
58. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		59. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		60. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
61. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		62. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		63. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
64. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		65. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		66. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
67. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		68. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		69. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
70. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		71. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		72. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
73. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		74. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		75. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
76. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		77. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		78. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
79. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		80. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		81. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
82. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		83. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		84. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
85. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		86. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		87. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
88. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		89. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		90. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
91. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		92. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		93. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
94. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		95. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		96. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
97. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		98. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		99. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	
100. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		101. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>		102. SIGNATURE OF REINTERMENT CLERK <i>John Doe</i>	

BUREAU V. S.

NOV 2 1956

RECEIVED

10390

CERTIFICATE OF DEATH

10380

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		c. LENGTH OF STAY IN 1b <u>70 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>	
		d. STREET ADDRESS <u>Route # 144</u>	
3. NAME OF DECEASED (Type or print) <u>EFFIE</u> First <u>MARY</u> Middle <u>THOMAS</u> Last		4. DATE OF DEATH <u>October 25</u> 19 <u>56</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1884</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>72</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James H. Bond</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>John A. Thomas - Cooksville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest, Coronary Thrombosis,</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Cerebral vascular</u> DUE TO (c) <u>accident (at side).</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April</u> , 19 <u>54</u> , to <u>Oct. 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct. 25</u> , 19 <u>56</u> , and that death occurred at <u>7:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Sykesville, Md.</u> DATE SIGNED <u>10-26-56</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-28-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cooksville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>10-26-56</u> DATE	24b. REGISTRAR'S SIGNATURE <u>C. Harry Ween</u>

BUREAU V. S.

9561 62 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10381

CERTIFICATE OF DEATH

Reg. Dist. No.

192

10391

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Howard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariottsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mariottsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY WAYNE WAYS</u>		4. DATE OF DEATH Month Day Year <u>October 31 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 22 1871</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk -</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Adam Ways</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>	
17. INFORMANT <u>McGeorge B. Ways - Mariottsville, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 24, 1956</u> , to <u>Oct 31, 1956</u> , that I last saw the deceased alive on <u>Oct 30, 1956</u> , and that death occurred at <u>3 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. E. Martin</u> M.D.		ADDRESS (Street, city or town, state) <u>Randallstown, Md</u> DATE SIGNED <u>11/1/56</u>	
PHYSICIAN'S NAME (Type) <u>WM. E. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-2-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Springfield</u>		22d. LOCATION (City, town, or county) (State) <u>Springfield, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight - Springfield, Md</u>		24a. REC'D BY REGISTRAR <u>NOV 7 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Miss Kelly</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10392

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Highland Manor</u>				d. STREET ADDRESS <u>13 Mallow Hill Ave</u> * IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Henry F. Wiesner Jr.</u> First Middle Last				4. DATE OF DEATH <u>10/23/56</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/1872</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>md</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wiesner</u>				14. MOTHER'S MAIDEN NAME <u>Greiner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>Edwin P. Wiesner Jr.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 acute myocardial infarction</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Cardiac Failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>56</u> to <u>10/16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/16</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Max J. Miller</u> M.D.				ADDRESS (Street, city or town, state) <u>5226 Balt Nat Hl</u> DATE SIGNED <u>10/25/56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/26/56</u>		<u>Lorraine</u>		<u>Balt Co md</u>	
23a. FUNERAL DIRECTOR'S SIGNATURE <u>Max Miller</u> ADDRESS <u>28</u>				24a. REC'D BY REGISTRAR <u>OCT 29 1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. E. Laughman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED